








LA Care
HEALTH PLAN

My Medication List

My Doctor's Name: _____ My Name: _____

My Doctor's Phone Number: _____ Today's Date: ____/____/____

	When do I take this drug?	Drug Name	Why do I take this drug?	How much should I take?	How to take this drug
Morning					
Noon					
Evening					
Bedtime					
Only when I need it					

My Next Doctor's Visit: ____/____/____

If yes, what are your questions? (Please list)

Do you have questions for your doctor?

☐ Yes

☐ No

LA1079 07/14